



# GRANDCHILD Certification Form

|                           |  |            |                   |   |               |
|---------------------------|--|------------|-------------------|---|---------------|
| <b>Member Information</b> |  | Agency     |                   | <input type="checkbox"/> New <input type="checkbox"/> Recertification |               |
| Last Name                 |  | First Name |                   | Middle Initial  | Employee ID # |
| Mailing Address           |  | City       |                   | State   | Zip Code      |
| Work Phone Number         |  |            | Home Phone Number |   |               |

|   |                            |  |                        |                |
|---|----------------------------|--|------------------------|----------------|
| <b>Grandchild Information</b> • Please complete this form for each grandchild you are requesting to cover |                            |  |                        |                |
| Last Name   |                            | First Name   |                        | Middle Initial |
| Gender  | Date of birth (mm/dd/yyyy) | Is the child disabled?                                   | Social Security Number |                |
| Male <input type="checkbox"/> Female <input type="checkbox"/>   |                            | Yes <input type="checkbox"/> No <input type="checkbox"/> |                        |                |

**Eligibility and Documentation** • Check one of the two boxes to select the authority under which you are requesting to cover your grandchild and provide the required documentation.

☐ Employee Labor Agreements/Compensation Plans: the grandchild is unmarried and dependent upon a covered grandparent (you or your spouse) for his or her principle support and maintenance and lives with the covered grandparent and your child (the parent of the grandchild) must be unmarried and under age 19. You must include a copy of your:

- grandchild's birth certificate, naming your (or your spouse's) child as your grandchild's parent and
- child's birth certificate, naming you (or your spouse) as parent and
- most recent federal tax return listing this child as your dependent and
- a document dated within the last 6 months establishing that this grandchild currently resides with you

☐ Minnesota Statute 62A.042: the grandchild is financially dependent upon a covered grandparent (you or your spouse) and has resided with that covered grandparent continuously from birth. You must include a copy of your:

- grandchild's birth certificate, naming your (or your spouse's) child as your grandchild's parent and
- child's birth certificate, naming you (or your spouse) as parent and
- most recent federal tax listing this child as your dependent and
- federal tax return from the year this grandchild was born confirming continuous residence and support and
- a document dated within the last 6 months establishing that this grandchild currently resides with you

If you (or your spouse) have adopted your grandchild or are the foster parent of your grandchild you do not need to complete this form.

|  |     |
|--|-----|
| <b>Responsible Party</b>   |     |
| Are you (or your spouse) responsible for at least 51% of this child's principal support and maintenance? | Yes |
| No   |     |
| Does the grand child live with you?  | Yes |
| No   |     |
| When did the grandchild begin living with you? _____   |     |
| If you did not circle "yes" to each of these questions, the grandchild is not eligible.                  |     |

## Certification

By signing this form, I certify that the information I have provided is true, complete, and correct. I acknowledge that I am responsible for notifying SEGIP within 30 days of any change in this child's status or of any change in the child's eligibility under the program. I understand that SEGIP may request documents showing continued eligibility at any time.

I understand that knowingly providing false, incomplete, or misleading information may be fraud or intentional misrepresentation of a material fact and may result in denial or loss of benefits, I may be required to repay any claims paid during the period the child as ineligible, and I may be subject to disciplinary action.

**Employee's signature**\_\_\_\_\_ **Date**\_\_\_\_\_

Questions – need more information – please call SEGIP at 651-355-0100. Scan and email completed form to [segip.mmb@state.mn.us](mailto:segip.mmb@state.mn.us), fax to 651-296-5445 or mail completed form and documentation to:

Minnesota Management & Budget  
SEGIP  
400 Centennial Office Building  
658 Cedar Street, St. Paul, Minnesota 55155

### Notice of Collection of Private Data

Minnesota Management & Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). We are requesting private data from you through a vendor, HMS as part of a dependent eligibility verification audit. This notice explains why we are requesting the private data about you, your spouse, and dependents, how we will use it, who will see it, and your obligation to provide the data.

#### Why we ask you for this data?

We ask for this data so that we can successfully administer SEGIP. This information is used to process your request to add or change coverage for yourself, your spouse, or dependents. The requested information helps us to determine eligibility, to identify you and your spouse, and dependents, and to contact you or your spouse, and dependents. The information is also used to develop new programs, ensure current programs effectively and efficiently meet member needs, and to comply with federal and state law and rules. We need the social security numbers and birth dates of your spouse and dependent to offer insurance continuation, process a death benefit, to ensure we are matching them to the correct insurance benefit transaction and to comply with federal Medicare coordination laws (in compliance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173)).

If you provide any data about you, your spouse, or dependents that is not necessary, we will not use it for any purpose.

#### Do you have to provide the private data requested?

You are not required to provide all of the data but certain data must be collected. If you do not provide the requested data, your dependent(s) may be approved to participate in the program or may lose coverage under the program. If you do provide the data, it will be used as described.

#### Who else may see this data about you and your spouse and dependents?

We may give data about you, your spouse, and dependents to the plan administrator you have chosen, SEGIP's other representatives, vendors and actuary; the Legislative Auditor; the Department of Health; the Department of Commerce; and any law enforcement agency or other agency with the legal authority to the information; and anyone authorized by a court order. In addition, the parents of a minor may see data on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that data.

#### How else may this data be used?

We can use or release this data only as stated in this notice unless you give us your written permission to release the data for another purpose or to release it to another individual or entity. The data may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the data or to use it for another purpose.